NEW CLIENT INFORMATION FORM– MINOR UNDER AGE 18

CLIENT INFORMATION:

Name:_____ Birthdate:_____ Age:_____

Address:_____ Home Number:_____

City:_____ Patient's Cell Number (if applicable):

_____

State:_____ Zip:_____ Okay for me to text client? Y N NA

Okay to leave a voicemail: Y N NA

Patient email: _____ Okay for me to email client? Y N NA

*** If YES to email or texting, please be sure to read and sign Informed Consent Related to use of Technology.***

Client's ethnic background? _____ Religious/Spiritual orientation? _____

How were you referred to my office? _____

May I thank them for the referral? Y N

FAMILY INFORMATION:

Parent 1 Name: _____ Birthdate:_____ Age:_____

Home Address (if different from child) Home Number:_____

_____ Cell Phone Number:_____

_____ Email: _____

Employer: _____ Okay to text? Y N

Profession: _____ Okay to leave a voicemail: Y N

Okay to email? Y N

Parent 2 Name: _____ Birthdate:_____ Age:_____

Home Address (if different from child) Home Number:_____

_____ Cell Phone Number:_____

_____ Email: _____

Employer: _____ Okay to text? Y N

Profession: _____ Okay to leave a message: Y N

Okay to email? Y N

PERSONS LIVING IN CHILD'S RESIDENCE:

Name:	Age:	Relation to child:
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

IF PARENTS ARE SEPARATED OR DIVORCED, PLEASE COMPLETE:

Who is the "custodial" parent? _____

Frequency of visitation with "non-custodial" parent? _____

Person's living in "non-custodial parent's home:

Name:	Age:	Relation to child:
_____	____	_____
_____	____	_____
_____	____	_____

SCHOOL INFORMATION:

School: _____ Special Classes/provisions/IEP, etc.? _____

Grade: _____ _____

PSYCHIATRIC HISTORY:

Has child previously received therapy? _____

Name of therapist: _____

Has child previously been hospitalized? _____ If so, where? _____

Family history of mental illness or alcohol/drug use? (Child's parents, grandparents, aunts/uncles, siblings) If so, please describe briefly.

_____

_____

Please list all medications the patient is currently taking and the general reason for each medication:

_____

_____

Please list the patient's medical doctor's name and telephone number who prescribes the above medication:

Name: _____ Number: _____

CHILD'S PEDIATRICIAN/PHYSICIAN:

Name: _____ Number: _____

BILLING INFORMATION:

Responsible Party: _____ Relation to child: _____

Address (if different than above) Insurance Company: _____

_____ Policy or ID #: _____

_____

* Please see consent form for information on billing insurance company as out of network*

Briefly describe the reasons you (or your child) are seeking services and what your goals for therapy are at this time:

In what ways have you (or your child) dealt with this problem/these problems thus far?

Is there anything else that you think is important for me to know about you (or your child)?

CONSENT

I consent to treatment, certify that the above information is accurate and authorize the release of medical information to other necessary parties, including insurance claim requests.

Parent Signature: _____ Date: _____